BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

AMY J. FRICKEY	)	
Claimant	)	
	)	
VS.	)	
	)	
JOSTENS, INC.	)	
Respondent	)	Docket No. 1,032,942
	)	
AND	)	
	)	
TRAVELERS INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Claimant requested review of the June 17, 2010, Award entered by Administrative Law Judge Rebecca A. Sanders (ALJ). The Board heard oral argument on December 8, 2010. The Division's Acting Director, Seth Valerius, appointed E.L. Lee Kinch to serve as Appeals Board Member Pro Tem in place of retired Board Member Carol Foreman. Roger D. Fincher, of Topeka, Kansas, appeared for claimant. John F. Carpinelli, of Topeka, Kansas, appeared for respondent and its insurance carrier (respondent).

This is a claim for alleged injuries to claimant's bilateral knees and low back, as well as for psychological impairment. In the June 17, 2010, Award, the ALJ determined claimant was entitled to receive permanent disability benefits for a 15 percent impairment to her left lower extremity. The ALJ concluded the presumption of permanent total disability did not apply because there was only permanent impairment to the left knee rather than to both knees. Further, the ALJ found claimant did not have permanent impairment to the low back. Additionally, the ALJ determined claimant's chronic psychological problems were not caused or exacerbated by the work-related accident. Finally, the Judge did not find that there was an overpayment of temporary total disability benefits.

The Board has considered the record and adopted the stipulations listed in the Award. In addition, during the deposition of Dr. Carabetta, the parties stipulated to the admission of Chapter 3 of the AMA *Guides*.[1]

ISSUES

Claimant argues the ALJ erred in her findings on several issues, namely, that claimant had no permanent impairment to her right lower extremity or lumbar spine, that claimant had no permanent psychological impairment, that claimant was not permanently and totally disabled, and that claimant was not entitled to a work disability.

With regard to functional impairment, claimant requests the Board to at least give equal weight to the opinions of Drs. Lynn D. Curtis (42 percent impairment) and Vito J. Carabetta (15 percent impairment) in regard to the extent of claimant's left lower extremity impairment, find claimant sustained a 7 percent permanent impairment to her right lower extremity, and find that claimant sustained a 5 percent whole person impairment to her lumbar spine. Claimant asserts she is permanently and totally disabled. If the Board finds claimant is not permanently and totally disabled, claimant contends she should be awarded a work disability between 79.15 percent and 85.7 percent based upon a 100 percent wage loss and a task loss between 58.3 percent and 71.4 percent (based upon the task loss opinions of Dr. Curtis).

Respondent contends the ALJ's determination that claimant sustained only permanent impairment to her left lower extremity should be affirmed as claimant only proved functional impairment to her left lower extremity and failed to prove impairment to her right leg or low back and failed to prove psychological impairment. Further, respondent asks the Board to determine that strict statutory construction of the Workers Compensation Act does not permit benefits for a psychological injury/traumatic neurosis and requires actual loss of claimant's legs for the presumption of permanent total disability to apply. Respondent argues claimant failed to prove permanent total disability. Additionally, respondent argues claimant failed to prove her entitlement to a work disability. Finally, respondent maintains temporary total disability benefits were overpaid after November 13, 2007, as claimant had reached maximum medical improvement (MMI).

The issues for the Board's review are:

(1) What is the nature and extent of claimant's functional disability? Did claimant prove impairment to her right lower extremity or her low back?

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[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

(2) Does the Workers Compensation Act (Act) permit benefits for a psychological injury/traumatic neurosis? If so, did claimant prove a psychological impairment?

(3) Does the Act require actual total loss of use or amputation of claimant's legs for the presumption of permanent total disability to apply? Is claimant permanently totally disabled?

(4) If claimant is not permanently totally disabled, is she entitled to a work disability? If claimant is entitled to a work disability, what is the nature and extent of that disability?

(5) Was there an overpayment of temporary total disability benefits?

FINDINGS OF FACT

As of January 11, 2007, claimant had been employed at Jostens for 12 1/2 years as a case maker helper. Her job was to get supplies for the case maker. In doing so, she had to pull pallets, carry water, get glue, and empty trash. On January 11, 2007, claimant was asked to get a wooden pallet. She picked up the pallet and turned toward the right, and her left knee buckled and she went down to the floor.

Claimant was taken to St. Francis Hospital, where she was seen by Dr. Donald Mead. Dr. Mead's records indicate that claimant told him she was twisting to get up and her patella dislocated. Claimant told him this had happened several times in the past. Dr. Mead diagnosed her with patella dislocation and advised her to wear a knee immobilizer. She was placed on crutches and referred to orthopedics.

Claimant returned to St. Francis Hospital on January 18, 2007, where she was seen by Dr. Vogt. She said her referral to orthopedics was denied and the pain in her left knee was getting worse. Examination of the left knee showed a slight swelling and tenderness to palpation. She was again referred to orthopedics.

On April 9, 2007, claimant was at home when she got up to go to the bathroom and her right knee gave out on her. She went to the emergency room at St. Francis Hospital, where she told the doctor she felt a snapping sensation in her right knee and had been unable to bear weight on that leg since. She complained of pain and immobility in the right knee. An x-ray of the knee was negative for fracture or dislocation. Claimant was given a knee immobilizer for her right knee, and the immobilizer for her left knee was replaced. She returned to the emergency room on April 20, 2007. She was complaining of pain in both knees. She told the doctor that she had a work-related injury to her left knee and that she now has compensatory right knee strain secondary to wearing a splint on the left. Claimant's examination revealed she had diffuse tenderness to palpation of both knees, and she was diagnosed with chronic knee pain.

Claimant testified that about the same time she injured her right knee (April 2007), her low back began to bother her. Claimant returned to St. Francis Hospital on May 10, 2007, May 22, 2007, and June 1, 2007, each time complaining of bilateral knee pain or swelling. None of the records from these visits, nor the records from the April 2007 visits, indicate that claimant complained of low back pain. Claimant was also seen on June 15, 2007, by Dr. Edward Prostic, at the request of claimant's attorney. She told Dr. Prostic that because of difficulties with her left knee, she developed problems on her right. Dr. Prostic recommended claimant have intensive training on a stationary bicycle and, if she did not make good progress in six weeks, surgery should be considered. She did not complain of low back pain to Dr. Prostic.

Dr. Lowry Jones, Jr., was authorized to treat claimant by respondent, and he first saw claimant on July 2, 2007. After examining claimant, Dr. Jones said her primary left knee pain was associated with an acute patellofemoral subluxation or dislocation. Her right knee appeared to have a similar problem to a much lesser degree. He limited all kneeling, squatting, climbing and crawling, and indicated she should be allowed to change positions. He suggested she not do any lifting below knee level. On July 13, 2007, Dr. Jones performed a left knee arthroscopy.

Claimant had physical therapy and follow up visits with Dr. Jones. On November 13, 2007, Dr. Jones noted her range of motion was about normal. She had full extension actively but complained of pain. Her function was improved but still weak. Dr. Jones believed her effort was limited. He concluded claimant was at MMI and continued her previous restrictions, saying they should be considered permanent.

Claimant was seen by Dr. Peter Bieri on December 10, 2007, at the request of claimant's attorney. Claimant complained of pain in her left knee, compensatory pain in her right knee secondary to gait abnormality, and low back pain. After examining claimant, Dr. Bieri stated that she was not at MMI and recommended that she have a formal evaluation of her lumbar spine and left knee. He gave claimant temporary restrictions from activities involving sustained standing or unassisted ambulation. He permitted sedentary activity within claimant's pain tolerance, along with the use of appropriate pain medication.

Respondent sent claimant to Dr. Steven Hendler for examination on July 8, 2008. She told him she had surgery on her left knee but had no improvement. She also said that in April 2007 she got up to go to the bathroom and heard a snap and had a sudden onset of pain in her right knee. She claimed she had an onset of back pain in the summer of 2007. When examining claimant, Dr. Hendler noted that gait and station were abnormal. On indirect observation, when she did not know she was being observed, she was noted to have a much more normal pattern, especially as related to stride length. Dr. Hendler also viewed a videotape of claimant and said her presentation in the evaluation was different from that he observed on the videotape. Dr. Hendler diagnosed claimant with internal derangement, left knee, with patellar subluxation status post lateral release and arthroscopic surgery; right knee pain; and back pain. He did not believe the right knee

condition or low back condition were related to her injury. In looking at her gait, he thought it was possible she might have mild mechanical back pain, but he could not identify any ongoing abnormalities that would suggest significant pathology in the back. He believed that claimant was able to work but suggested work hardening. He believed that claimant could perform light activity, including occasional standing and walking, and she could sit in unlimited quantities. He noted she probably would have difficulty with stair climbing, kneeling, and squatting but that work conditioning could improve her ability to perform those activities.

Dr. Thomas Samuelson saw claimant on February 6, 2009, at the request of respondent, for an examination. Claimant's chief complaint was left knee pain. On examining the left knee, Dr. Samuelson found her range of motion to be 0-0-125. She had good quad tone, and there was no effusion. She had tenderness over the medial joint line and a mild apprehension. Lachman's Test was negative. She had no collateral ligament laxity. On examining the right knee, Dr. Samuelson found range of motion to be 0-0-135. There was no tenderness, no patellofemoral compression pain, and a negative apprehension. There was no collateral ligament laxity. Dr. Samuelson diagnosed claimant with left patellofemoral chondromalacia, but he did not believe she was in need of surgical intervention. He told claimant the prior surgical procedure was well done and appeared to have improved her symptoms.

Dr. Lynn Curtis, who is board certified in rehabilitation medicine, evaluated claimant on two occasions, both at the request of claimant's attorney. He first saw claimant on January 22, 2007. He performed a physical examination, and took a history. Claimant told him she had a twist and fall injury at work on January 11, 2007. Dr. Curtis diagnosed her with a left knee injury with patellar subluxation, medial lateral ligamentous injury, possible derangement, and a lumbar strain. Claimant had been given crutches in the emergency room and then developed back pain that became gradually worse. When Dr. Curtis saw claimant on January 22, 2007, she said her back pain was a level 7 out of 10. Dr. Curtis attributed her lumbar strain to the slip and fall, plus her abnormal gait and inappropriate use of the crutches.

Dr. Curtis next saw claimant on October 14, 2008. As of that date, Dr. Curtis diagnosed her with lumbar strain; left knee injury, patellar injury, medial and lateral ligament injury, status post surgery to the left knee; and right knee injury, medial ligamentous strain. Claimant told Dr. Curtis she continued to have low back pain on the right side in the lumbar region. She said her left knee pain was a 5 out of 10, but her right knee was better.

Based on the AMA *Guides*, Dr. Curtis rated claimant as follows:
For medial laxity of the right knee, 7 percent impairment of the right lower extremity
For lumbar strain, 5 percent impairment to the body as a whole
For the left knee:
For quadriceps weakness, 12 percent of the left lower extremity

For medial laxity, moderate, 17 percent of the left lower extremity
For lateral knee laxity, moderate, 17 percent of the left lower extremity
For patellar compression, 5 percent of the left lower extremity
For thigh atrophy, 3 percent of the left lower extremity

The percentages of impairment for the left lower extremity combine for a 42 percent permanent partial impairment to the left lower extremity. The 42 percent impairment for the left lower impairment converts to a 17 percent whole person impairment. Combining 17 percent whole person impairment for the left lower extremity and the 5 percent whole person impairment for the lumbar spine calculates to a 21 percent whole body impairment.[2]

Dr. Curtis placed permanent restrictions on claimant of working at a sedentary level. She should have a sit-stand option at work. She should lift no more than 10 pounds from waist to chest or more than 10 pounds off the floor. She should only occasionally bend or stoop. She should not crawl, climb, walk at unprotected heights, or walk on ladders.

Dr. Curtis reviewed the task lists of Mr. Santner and Mr. Cordray. Of the 7 tasks on Mr. Santner's list, he believed claimant was unable to perform 5 for a 71 percent task loss. Of the 12 tasks on Mr. Cordray's list, Dr. Curtis opined that claimant was unable to perform 7 for a 58 percent task loss. Dr. Curtis said that considering claimant's restrictions and educational level, it was unlikely she would be able to obtain full-time work.

Dr. Vito Carabetta is board certified in physical and rehabilitation medicine. He examined claimant on two occasions, May 13, 2008, and December 2, 2009, both at the request of respondent. At Dr. Carabetta's examination of claimant on May 13, 2008, she was complaining of bilateral knee pain and low back pain. She said her right knee pain started in April 2007. Claimant had a limp. She had no ligamentous laxity, either medial or lateral. The neurologic examination of her low back was intact. She had some limitation in terms of her forward flexion ability, but she had full range of motion in other directions. She had no muscle spasm. She had 3+ diffuse tenderness, which is a substantial amount, but she had no focal tenderness. Dr. Carabetta said that aside from her remarkable diffuse subjective tenderness, there were no real findings. There were no objective findings. Dr. Carabetta believed that claimant was dealing with mechanical low back pain.

Dr. Carabetta evaluated claimant again on December 2, 2009. She again complained of pain in both knees and her back. She no longer had a limp and said she had not been limping for some time. Dr. Carabetta did not find anything in claimant's right knee to suggest that the knee had been torn. An MRI performed on claimant's left knee on May 15, 2007, showed that the anterior and posterior cruciate ligament and the medial and lateral collateral complexes were all normal in appearance and signal intensity. In

[2] There does not seem to be any explanation as to why the 7 percent impairment to claimant's right lower extremity was not included in Dr. Curtis' calculation of her whole body impairment.

examining claimant's low back, Dr. Carabetta said her lumbar range of motion was somewhat better for forward flexion but slightly limited in terms of extension. Lateral flexion to either side was normal, but she complained of symptoms like she did in his earlier examination. Dr. Carabetta, again, found no objective findings in terms of claimant's low back. Also, he found nothing wrong with either the anterior or the posterior cruciate ligaments of claimant's knees.

Using the AMA *Guides*, Dr. Carabetta rated claimant as having a 15 percent permanent partial impairment to her left lower extremity. He did not believe that claimant had any impairment in terms of her right knee. He also did not believe that claimant had any impairment stemming from her low back. He said that the AMA *Guides* require both objective and subjective complaints to qualify for a DRE Category II, 5 percent rating. He said that claimant's claimed tenderness was nonspecific and out of proportion to any examination findings.

Dr. Carabetta recommended that claimant be restricted to relatively sedentary to light work. He said claimant would need to change from a standing to a sitting position as needed to limit her knee complaints. He believed claimant could stand for a short amount of time and walk short distances, but she should not be up on her feet for a protracted amount of time or participate in extended walking. Furthermore, he said that claimant should not participate in any activities involving squatting, kneeling, crawling or climbing. All her restrictions were provided for claimant's left knee condition.

Dr. Carabetta stated if a sedentary or sit-down job were available to claimant and if she had the skills for that job, he believed she would still be employable. He reviewed task lists prepared by Dick Santner and Terry Cordray. Of the 7 tasks on Mr. Santner's list, Dr. Carabetta opined that claimant would be unable to perform 3 for a 43 percent task loss. Of the 12 tasks on Mr. Cordray's list, Dr. Carabetta believed claimant would be unable to perform 6 for a 50 percent task loss.

In claimant's application for hearing, dated January 18, 2007, seven days after her injury, she claimed psychological stress from her injury. She testified she kept having nightmares of the incident where she twisted her knee again and again. Claimant had been diagnosed with depression before the accident of January 11, 2007. Between 2001 and 2007, claimant had been prescribed Celexa, Effexor, and Wellbutrin. The medical records of Dr. Michael Murphy, claimant's personal physician, from July 2002 to May 2005 mention claimant's complaints of being irritable, having poor patience, and being quick to anger. She complained of an increased need for sleep and a care-less attitude. She also complained of night sweats, moodiness, and struggles with weight gain.

Claimant testified she continues to have trouble sleeping, she cries more often than before the accident, and has anxiety attacks and anger issues. Claimant said her level of anxiety before her accident was a 1 or 2, and now it is a 9 or 10. Claimant has received mental health treatment since her accident at Valeo. She tried to commit suicide in

September 2008 when she was going through her divorce and said it was because she was depressed about her divorce and knee problems. She said the primary reason she has depression, anxiety and anger is because of her pain and not being able to work.

Dr. Jeanne Frieman is a psychologist in private practice. She first saw claimant at claimant's attorney's request on January 24, 2007, 13 days after the work related accident, and then again on February 17, 2010.

On January 24, 2007, claimant was on crutches. Claimant told Dr. Frieman she was having psychological or emotional symptoms that were related to her physical injury. Claimant said she was depressed, was losing weight, was dysphoric, had a poor appetite, and had trouble sleeping. Claimant also said she was restless, impatient and short tempered. She cried for little reason. She had lost interest in things she used to enjoy, withdrew from other people, and had little interest in sex. She had little confidence and felt hopeless and worthless. She had trouble concentrating. Claimant also described symptoms of anxiety and posttraumatic stress disorder primarily due to a house fire and childhood abuse. Claimant had issues related to her work injury as well as some underlying issues.

Dr. Frieman gave claimant several tests, including a wide range achievement test, a psychiatric diagnostic interview-revised test, and the Test of Memory Malingering (TOMM) for malingering. Claimant had a nearly perfect score on the first trial of the TOMM, which Dr. Frieman said showed that claimant was not likely to be malingering. Dr. Frieman diagnosed claimant with depressive disorder not otherwise specified, posttraumatic stress disorder, compulsive disorder, and generalized anxiety disorder. She believed claimant needed therapy and medication. Dr. Frieman's report of January 2007 indicated that there was no evidence of any depressive symptoms before the accident of January 11, 2007.

Dr. Frieman saw claimant again on February 17, 2010. In the 3-year interim since she had seen claimant, claimant had surgery on her knee. Claimant had also attempted suicide in September 2008, during a period in which she was getting a divorce.

Dr. Frieman believed that claimant had a decompensation as a result of the accident she suffered in 2007 and another decompensation as a result of the divorce. Dr. Frieman believed that claimant continued to be depressed and her depression is in part the result of her inability to work. Claimant told her she had been fired because Dr. Murphy had not sent respondent a medical absence excuse, but also said she had been having trouble keeping up with the work. She could not do the silk screening job accurately and could not do it fast enough.

With respect to activities of daily living, Dr. Frieman said that claimant still needs assistance doing housework. Claimant's social skills are moderately impaired due to withdrawal from others, irritability, mood swings, and reduced ability to engage in sexual behavior. Claimant's ability to concentrate and her persistence and pace are impaired at

the moderate level. Claimant's adaption area is moderately impaired. Dr. Frieman found claimant had an average total impairment of 25 percent. This 25 percent is due to depression caused by the accident and claimant's limitations since the accident.

Dr. Frieman said claimant has bipolar disorder, obsessive compulsive disorder, and generalized anxiety. She believed claimant should be treated with therapy and medication. She believed claimant's posttraumatic stress disorder was due mostly to her childhood abuse and house fire. Dr. Frieman believed that claimant's suicide attempt was focused on her divorce from her husband.

After reviewing Dr. Caffrey's report, Dr. Frieman took issue with his choice of tests and the conclusions he reached from those tests because Dr. Frieman said claimant did not have the intelligence or the reading ability level to do those tests in a valid manner. She also disagreed with his conclusion that claimant had a somatoform disorder because there really was something physically wrong with claimant's knee.

Dr. Patrick Caffrey is a psychologist with a practice in Kansas City, Missouri.[3] He also does vocational evaluations and is a certified rehabilitation counselor. He evaluated claimant on two occasions, March 19, 2007, and March 22, 2010. On both occasions he interviewed claimant and performed psychological testing. He administered the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) both times, and the Millon Clinical Multiaxial Inventory-III (MCMI-3), on claimant's first visit, neither of which was administered by Dr. Frieman. Dr. Caffrey said these were both objective personality inventories. He said it was important to have objective personality inventories to be able to have validity.

On March 19, 2007, claimant complained to Dr. Caffrey of depression originating from a work injury on January 11, 2007. She complained of feelings of worthlessness, claimed she could not do her household chores, and felt like a burden. She cried more often than she used to. She said she had suicidal thoughts but no plan or attempt. She complained of panic attacks. She felt moody. She tended to throw objects when frustrated. She had engaged in social withdrawal and tends to stay home more than before the injury. Dr. Caffrey noted that claimant brought with her a prepared-in-advance list of her complaints and a letter from her attorney's office with suggestions for the appointment. She had a page-long list of "Things I Cannot Do Because of My Injury."

The result of claimant's fake bad score (FBS) on the MMPI-2 was a 34, which was significantly elevated. Dr. Caffrey said that score indicated claimant was over reporting symptoms and problems as it related to her emotional status. Dr. Caffrey said that raw scores on the FBS above 22 raise concerns about the validity of self-reported symptoms and raw scores above 28 raise very significant concerns about the validity of self-reported

[3] Dr. Caffrey has a Ph.D. in Vocational Education for the Handicapped and a M.S. degree in Psychology.

symptoms. The MMPI-2 has 8 validity scales. He said many of the clinical scales were significantly elevated in claimant's test that ordinarily would be associated with severe psychiatric disturbances. Dr. Caffrey said both scales 7 and 8 were extremely elevated, but scale 8 was slightly more elevated than 7, which he believed indicated chronicity of problems rather than a reaction to an acute event.

Dr. Caffrey concluded that claimant was exaggerating her claims of disability in the context of her emotional status. She has a tendency toward somatization with hypochondriacal features. She had a clearly established history of major depression which was not caused by the knee injury. Either the press of persistent troublesome events or the impact of biological dysfunction has resulted in a variety of chronic symptoms, such as fatigue, loss of energy, inefficiency, and inability to concentrate. Dr. Caffrey found no evidence to suggest a diagnosis of generalized anxiety disorder or posttraumatic stress disorder. Claimant met the diagnostic criteria for adjustment disorder with mixed anxiety and depressed mood, histrionic personality disorder with self-defeating personality traits, schizotypal personality features, and paranoid personality features.

Dr. Caffrey believed claimant was experiencing typical reactions to what appeared to be an acute injury to her left knee. He concluded, within a reasonable degree of psychological certainty, that claimant had no emotional sequelae, neurosis, or clearly identifiable psychological problems that resulted directly or indirectly from the left knee injury.

When Dr. Caffrey saw claimant again in March 2010, she reported she had been diagnosed with bipolar disorder with symptoms that included irritability, rapid mood cycling, and inability to finish projects that she starts. Claimant acknowledged she took 6 Darvocets in a suicide attempt on September 19, 2008. She has gone through a divorce. A former boyfriend attempted to rape her in January 2010.

Dr. Caffrey again gave claimant several tests, including again giving claimant the MMPI-2. In completing the Beck Anxiety Inventory, claimant posted a score of 42, which falls in the severe range for intensity of anxiety. But Dr. Caffrey said on observation, claimant did not seem fidgety, nervous or agitated. In the MMPI-2 FBS, claimant had a score of 27, above the cut-off of 22, raising concerns about the validity of self-reported symptoms. Dr. Caffrey performed a Validity Indicator Profile (VIP), another symptom validity test. The VIP is broken up into two sections, verbal and nonverbal. Claimant's overall test was valid for the nonverbal subtest, meaning claimant displayed adequate levels of effort. The verbal subtest, however, was invalid. The response dial showed inconsistent, and Dr. Caffrey said if claimant had put more effort into it, she would have gotten a higher score. Claimant described symptoms including problems with concentration and inability to sleep due to worries about not being able to work. Dr. Caffrey said it is difficult to apportion how much is related to her work injury because she also had other stressors. But he agreed some of her symptoms were in part related to the work-related injury.

Dr. Caffrey, after the psychological evaluation, again concluded that claimant was exaggerating her claims of disability in the context of her emotional status. The results also confirmed she was exaggerating her cognitive difficulties. Testing for her IQ in 2007 showed she had an IQ of 90, and testing in 2010 showed her IQ had decreased to 80. Dr. Caffrey said this was unusual and reflects suboptimal effort rather than genuine deterioration.

Test results supported the diagnosis of bipolar disorder, which Dr. Caffrey said was a psychiatric disease and was not caused by a work injury. He also said claimant had baseline conditions that preexisted her work injury that were ongoing. In all likelihood, claimant has limitations regarding her intellectual status, but there was reason to believe that she displayed suboptimal effort. Subtests related to verbal ability were most likely artificially lowered. She had significant elevation of the FBS. In all likelihood, claimant has difficulties with functioning due to her bipolar disorder, which is a psychiatric disease. There are indications in her medical history to suggest that she had poor adherence to her medication. Dr. Caffrey concluded, within a reasonable degree of psychological certainty, that claimant had no specific psychological injury related to her work injury. He opined that claimant's condition relates to psychiatric disease and not the January 11, 2007, work injury. Further, Dr. Caffrey believed that claimant was as capable of meeting the demands of competitive employment as she ever was. Dr. Caffrey said that claimant's bipolar disorder could interfere with her ability to work, but many people who are bipolar maintain adequate competitive employment.

Claimant's medical records from Valeo Behavioral Health Care were stipulated as being part of the record in this case. She was seen on an outpatient basis several times, the first being September 19, 2008. She complained of depression, fatigue, loss of pleasure, worthlessness, guilt, weight loss, preoccupation with death, impaired concentration, racing thoughts, rapid mood swings, irritability, and temper outbursts. She reported that she had the symptoms for several years off and on. She said she had suffered depression as a child. She has excessive worry and said that worry has been with her for years. Claimant's divorce was final on October 1, 2008, and she was last seen at Valeo on October 13, 2008. Although claimant told the therapist that she was off work due to a knee injury, it appears most of the discussion centered on her feelings about her divorce.

After claimant returned to work after her left knee surgery, respondent accommodated her restrictions by moving her to a silk screen job. Claimant was terminated by respondent on March 3, 2009. She testified that she had the flu and was off work five days. Matthew Beier, respondent's human resources manager, said she was terminated for missing five consecutive working days without obtaining approved leave, even though she had provided respondent with a doctor's note.

Richard Santner, a vocational rehabilitation counselor, evaluated claimant on September 17, 2008, at the request of claimant's attorney. He prepared a list of 7 tasks

that claimant performed in the 15-year period before her accident. Claimant told him that her only work history in that period was her work at respondent.

Claimant told Mr. Santner she completed school through the 9th grade. She has no GED. Mr. Santner testified that given her educational background, his evaluation of her, and her medical restrictions, he believes she is permanently and totally disabled. He said that any jobs she might be able to perform would be dependent on her being able to get her GED. He could not absolutely rule out her being able to get a job as a receptionist because she acknowledges having some computer and typing skills. But without a GED, it would be very difficult for her to get that type of job. If she had lighter restrictions, at some point she would likely be able to work. The capacity to be on her feet the majority of the workday would allow her to do jobs such as fast food, convenience store clerk, etc.

Terry Cordray, a vocational rehabilitation counselor, interviewed claimant on September 23, 2009, at the request of respondent. Mr. Cordray compiled a list of 12 job tasks that claimant performed in the 15-year period before her injury.

Mr. Cordray said that claimant was 34 years old and had work restrictions. She would be limited to light or sedentary jobs where she could change positions. Mr. Cordray said there are many jobs claimant could perform, such as cashier, hotel desk clerk, telemarketer, bill collector or receptionist. She could enhance her employability if she would get her GED, and given her work background, Mr. Cordray did not believe there was any reason she could not obtain her GED. She worked for respondent for 13 years without a GED and left, not because of a physical inability to do the job, but because of absenteeism.

Claimant was collecting unemployment benefits at the time Mr. Cordray saw her. In order to collect those benefits, claimant would have to verify that she was ready, willing and able to work.

Mike McKelvey, an investigator for Georgantas Claims, took surveillance of claimant on June 26, 27 and 28, 2008, on behalf of respondent. The DVD tapes do not show claimant walking with a limp. She was not using any assistive devices. She bent over several times without apparent problems, and was seen carrying a mesh basket on one occasion without apparent difficulty. It was unknown how much the basket weighed. However, it is evident from viewing the tapes that claimant climbed up and down stairs slowly and took the steps one at a time, apparently seeming to favor her left leg.

PRINCIPLES OF LAW

K.S.A. 2010 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2010 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An accidental injury is compensable under the Workers Compensation Act even where the accident only serves to aggravate a preexisting condition.[4] The test is not whether the accident causes the condition, but whether the accident aggravates or accelerates the condition.[5] An injury is not compensable, however, where the worsening or new injury would have occurred even absent the accidental injury or where the injury is shown to have been produced by an independent intervening cause.[6]

A preexisting mental condition is treated like any other health condition and if a work related accident aggravates, accelerates or intensifies the condition, it is compensable under the Workers Compensation Act.[7] But a psychological injury is not compensable under Kansas law unless it is directly traceable to a work-related physical injury.[8]

K.S.A. 44-510d(a) states in part:

> (a) Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to the compensation provided in K.S.A. 44-510h and 44-510i and amendments thereto, but shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total loss of use and as provided in the following schedule, 66 2/3% of the average gross weekly wages to be computed as provided in K.S.A. 44-511 and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c and amendments thereto. If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:
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> . . . .
>
> (16) For the loss of a leg, 200 weeks.
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[4] *Odell v. Unified School District*, 206 Kan. 752, 758, 481 P.2d 974 (1971).

[5] *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[6] *Nance v. Harvey County*, 263 Kan. 542, 547-50, 952 P.2d 411 (1997).

[7] *Boutwell v. Domino's Pizza*, 25 Kan. App. 2d 110, 959 P. 2d 469, *rev. denied* 265 Kan. 884 (1998).

[8] *Adamson v. Davis Moore Datsun, Inc.*, 19 Kan. App. 2d 301, 868 P.2d 546 (1994).

> (23) Loss of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

It is significant to note that in *Casco*,[9] the court found the presumption of permanent total disability applied despite the claimant having suffered only a partial loss of use of his bilateral upper extremities.

> When the workers compensation claimant has a loss of both eyes, both hands, both arms, both feet, or both legs or any combination thereof, the calculation of the claimant's compensation begins with a determination of whether the claimant has suffered a permanent total disability. K.S.A. 44-510c(a)(2) establishes a rebuttable presumption in favor of permanent total disability when the claimant experiences a loss of both eyes, both hands, both arms, both feet, or both legs or any combination thereof. If the presumption is not rebutted, the claimant's compensation must be calculated as a permanent total disability in accordance with K.S.A. 44-510c[10]

K.S.A. 44-510c states in part:

> (a) (2) Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, or both legs, or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall constitute permanent total disability. In all other cases permanent total disability shall be determined in accordance with the facts.
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> . . . .
>
> (b)(2) Temporary total disability exists when the employee, on account of the injury, has been rendered completely and temporarily incapable of engaging in any type of substantial and gainful employment. A release issued by a health care provider with temporary medical limitations for an employee may or may not be determinative of the employee's actual ability to be engaged in any type of substantial and gainful employment, except that temporary total disability compensation shall not be awarded unless the opinion of the authorized treating health care provider is shown to be based on an assessment of the employee's actual job duties with the employer, with or without accommodation.

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[9] *Casco v. Armour Swift-Eckrich*, 283 Kan. 508, 154 P.3d 494 (2007).

[10] *Id*. at Syl. ¶ 8.

K.S.A. 44-510e(a) states in part:

> If the employer and the employee are unable to agree upon the amount of compensation to be paid in the case of injury not covered by the schedule in K.S.A. 44-510d and amendments thereto, the amount of compensation shall be settled according to the provisions of the workers compensation act as in other cases of disagreement, except that in case of temporary or permanent partial general disability not covered by such schedule, the employee shall receive weekly compensation as determined in this subsection during such period of temporary or permanent partial general disability not exceeding a maximum of 415 weeks. . . . Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

ANALYSIS

The ALJ's Award contains findings of fact and conclusions of law that are accurate and supported by the record. The Board adopts those findings and conclusions as its own. In short, the Board agrees with and affirms the ALJ.

On January 11, 2007, claimant suffered a compensable injury to her left knee. Thereafter, due to overcompensation and an altered gait, claimant developed symptoms in her right knee and low back. Those injuries are compensable as a direct and natural consequence of her work-related left knee injury. However, claimant's right knee and low back conditions did not result in any permanent impairment of function that is rateable under the 4th edition of the AMA *Guides*. Claimant's total functional impairment is 15 percent to the leg resulting from her left knee injury.

Claimant has shown that she suffers from psychological conditions, including a generalized anxiety disorder and depression. However, the record fails to prove that those psychological conditions were caused by, permanently aggravated by, or that any rateable impairment is directly traceable to the work-related physical injuries. Claimant is not

entitled to an award of permanent disability compensation for any functional impairment resulting from her psychological conditions.

Claimant is not permanently and totally disabled. She is capable of engaging in substantial and gainful employment within her restrictions. Furthermore, because claimant's permanent impairment of function and permanent restrictions attributable to this accident are to the left knee only, claimant's permanent partial disability award is limited to the scheduled injury for the leg. Claimant cannot receive compensation for a work disability under K.S.A. 44-510e.

CONCLUSION

(1) Claimant's permanent impairment of function is 15 percent to her left lower extremity. She is entitled to permanent partial disability compensation based upon that percentage of impairment at the level of the leg. Claimant is not entitled to an award for permanent functional impairment to the right knee or back.

(2) Our Kansas appellate courts have held that the Kansas Workers Compensation Act permits benefits for psychological injuries that are directly traceable to a compensable physical injury. Claimant does not have a permanent psychological injury or impairment that is directly traceable to her physical injury.

(3) Our Kansas appellate courts have held that the Act does not require the actual total loss of use or amputation of a scheduled member in order to give rise to the presumption of a permanent total disability. There is no such presumption in this case because claimant did not suffer permanent impairment to both knees. Further, claimant is not permanently and totally disabled.

(4) Claimant is not entitled to an award of work disability. She does not have a general body disability, permanent impairment from a non-scheduled injury or permanent restrictions for a non-scheduled injury.

(5) Claimant did not reach maximum medical improvement before October 27, 2008. There was no overpayment of temporary total disability compensation.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca A. Sanders dated June 17, 2010, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of March, 2011.

_____
BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: Roger D. Fincher, Attorney for Claimant
John F. Carpinelli, Attorney for Respondent and its Insurance Carrier
Rebecca A. Sanders, Administrative Law Judge